

The impact of suicide bereavement on healthcare and community professionals

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Abstract

Aim

Approximately 60,000 people are affected by suicide bereavement in Ireland each year. The aim of this study was to examine the impacts on wellbeing and help-seeking behaviour of healthcare and community professionals bereaved by suicide within their role.

Methods

This was a quantitative, secondary data analysis study of the Irish Suicide Bereavement Survey. Of the 2,413 respondents, 252 (10%) participants identified as healthcare professionals (n=135, 54%), community professionals (n=51, 20%), and first responders (n=66, 26%). Chi-square tests were used to make comparisons between occupational groups for wellbeing, adverse impacts, supports accessed and barriers experienced.

Results

More than half of the professionals did not access any formal supports (n=130, 52%). There was a significant difference between the occupational groups for access to formal supports with fewer first responders accessing them (n=21, 32%) compared to community professionals (n=23, 45%) and healthcare professionals (n=78, 58%). First responders had the highest exposure to suicide in the workplace, with 70% (n=46) experiencing six or more suicide bereavements.

Discussion

These results signify the need for better access to postvention supports among professionals, particularly first responders who have a significant exposure to suicide in the workplace.

Introduction

Bereavement by suicide significantly impacts mental and physical wellbeing¹. In Ireland, with approximately 500 suicide deaths annually², an estimated 60,000 individuals are affected^{3,4}. Acute effects such as feelings of guilt, depression, anxiety and anger may be persistent without adequate support⁵. Healthcare and community workers exposed to suicide within their workplace may face similar challenges, including psychosomatic difficulties and suicidal ideation⁶, potentially affecting the care they provide. Unlike personal bereavement, professional exposure may involve individuals unknown to them, with varying impacts across occupational groups⁷. The severity of the reactions following a client suicide may depend on the relationship with the client, the context of the suicide and the supports received⁸.

Health professionals such as psychiatrists, psychologists and counsellors are at particular risk of being impacted by a patient suicide during their careers. One study of psychiatrists reported that between 50-70% had encountered a patient suicide during their careers⁹. Adverse impacts in these groups include stress, guilt, social withdrawal, low mood, and symptoms of post-traumatic stress disorder (PTSD), in addition to perceived responsibility^{10,11}. Community professionals, including social workers and educators, are also affected/impacted by suicide. School staff exposed to student suicides report grief, PTSD symptoms, and a need for specialised training and support^{12,13}. First responders are prone to work-related PTSD and other mental health challenges¹⁴. Indeed, when support programs do exist, a recent scoping review of prevention and early-intervention initiatives for first responders found that most had little measurable impact on mental health, and no validated prevention programs are currently available¹⁵.

Entering a suicide scene, particularly involving young people, is one of the most distressing situations they face¹⁶, yet validated measures of emotional impacts in this group are lacking⁷. Overall, research consistently shows healthcare and community professionals often rely on informal supports, with limited formal workplace provisions^{7,11,14}.

Using data from a national cross-sectional online survey, the overall aim of this study was to examine impacts on wellbeing and help-seeking behaviour of healthcare and community professionals bereaved by suicide within their role. The specific objectives were to (i) identify and characterise professionals by job description, type and number of bereavements, (ii) examine impacts of suicide bereavement on wellbeing, (iii) examine the experiences of accessing and engaging with supports.

Methods

This was a quantitative, secondary data analysis study using data from a national cross-sectional online survey, the Irish Suicide Bereavement Survey, conducted between October 2021 and February 2022^{3,17}. Participants were adults aged 18 years or older, residents of Ireland, and identified as being bereaved or affected by suicide. Ethical approval for the survey was granted by the Cork Research Ethics Committee (ECM 4 (j) 10/8/2021).

Of the 2,413 survey respondents, 354 (15%) reported being bereaved by suicide in a professional capacity. From the 354 participants, 57 (16%) were excluded from analyses as they did not report their occupational role and 45 (13%) were excluded as their occupations did not correspond to the group of interest. The final sample included 252 professionals – healthcare professionals, community professionals and first responders.

Variables examined included wellbeing, impacts of bereavement, supports accessed, and barriers to accessing supports. Sociodemographic details and information on bereavements (e.g., time since loss, relationship to the deceased) were collected.

Wellbeing was assessed using standardized scales: WHO-5 (World Health Organisation – Five Wellbeing Index), a five-point scale measuring current mental wellbeing (higher scores indicate better health)¹⁸; PHQ-ADS (Patient Health Questionnaire – Anxiety and Depression Scale)¹⁹, which measures depression and anxiety symptoms over the past two weeks; and a brief Grief Experience Questionnaire (GEQ), which assessed grief along with additional questions on suicidal ideation²⁰. Questions on the impacts of suicide bereavement and support access were adapted from a UK suicide bereavement survey²¹.

Adverse impacts included binary variables for mental health challenges, alcohol use, relationship problems, deterioration in physical health, prescription drug use, change of residence, financial problems, illegal/non-prescription drug use, hospitalisation for mental health problems, unemployment, gambling and homelessness.

Types of supports accessed were recoded into the variables – formal and informal supports. Formal supports include supports from mental health professionals and specialised supports including supports from charity support organisations. Informal supports include supports from family, friends, neighbours, work environment, and information resources. This grouping was based on a previously published UK study²².

Chi-square tests were used to compare groups across wellbeing, impacts, supports accessed, and barriers. Binary variables were created for religious beliefs, relationship status and ethnicity, multiple bereavements, number of deaths experienced in a professional capacity (grouped as '1-5' and '6 or more') and for professionals with personal suicide bereavement(s). All analyses were conducted using SPSS v27.

Results

Demographics

In total, 252 participants were identified as a healthcare (n=135, 54%), community professional (n=51, 20%) or first responder (n=66, 26%). Healthcare professionals were most commonly made up of nurses (n=54, 40%) and therapists/counsellors (n=16, 12%); while the most common groups of community professionals were teaching and education staff (n =19, 37%) and civil/public servants (n=12, 24%). The most common groups of first responders were members of the police (an Garda Síochána) (n=54, 82%) and emergency services (n=11, 17%).

Participant demographics were broadly similar across the three professional groups with the mean age for the sample being 44.29 years (Table 1). There was a significant difference in gender in the three occupational groups. The distribution of gender in the healthcare professionals and community professionals' groups were predominantly female (n=109, 81% and n=35, 69% respectively) whereas the first responders had a more even distribution with 53% being females (n=35). Most participants were of White Irish ethnicity (n=200, 97%), reported practising religious/spiritual beliefs (n=156, 76%) and were in a relationship (n=159, 77%).

Table 1 Demographic profile of professionals bereaved/ impacted by suicide (n=252)

Sample characteristic	Healthcare Professionals (n = 135)	Community Professionals (n = 51)	First Responders (n = 66)	Total (n = 252)	Chi-Square (df)	p-value
Gender					16.60 (1)	<.001
Female	109 (80.7%)	35 (68.6%)	35 (53.0%)	179 (71.0%)		
Male	26 (19.3%)	16 (31.4%)	31 (47.0%)	73 (29.0%)		
Age (years), mean (SD)¹	45.23 (10.37)	44.42 (11.17)	42.20 (8.36)	44.29 (10.09)	2.062 ² (2)	.129
Ethnicity³						
White Irish	105 (94.6%)	40 (97.6%)	55 (100.0%)	200 (96.6%)		
Other Background	6 (5.4%)	1 (2.4%)	0 (0.0%)	7 (3.4%)		
Participants with religious/ spiritual beliefs⁴						
Yes	85 (77.3%)	29 (72.5%)	42 (77.8%)	156 (76.4%)		
No	25 (22.7%)	11 (27.5%)	12 (22.2%)	48 (23.5%)		
Relationship Status⁵					1.81 (1)	.179
In a relationship/ partnership/married	91 (82.0%)	27 (65.9%)	41 (74.5%)	159 (76.8%)		
Not in a relationship (separated/divorced/widowed/sing le)	20 (18.0%)	14 (34.1%)	14 (25.5%)	48 (23.2%)		

¹Known for n=251 participants (99.6%). ²f-statistic. ^{3,5}Known for n=207 participants (82.1%). ⁴Known for n=204 participants (81.0%). ^{3,4}Groups were too small to compare with Chi-square.

Information on bereavement(s)

Most professionals reported being bereaved by more than one suicide (n=212, 84%) (Table 2). Overall, more than half of the participants experienced between 1-5 deaths in a professional capacity (n=145, 59%) and the majority had also experienced suicide in a personal capacity (n=154, 61%). There was a significant difference between the three occupational groups and the number of deaths experienced in their professional role, with first responders more likely to experience more deaths by suicide (6+ deaths = n=46, 70%).

Participants who had experienced multiple deaths by suicide were asked to identify one loss to focus on for most of the survey questions (Table 2). Just over a third of the sample answered the survey based on a professional relationship (n=89, 37). There was a significant difference between occupational groups and the relationship to the deceased. More healthcare professionals reported professional relationships to the deceased (n=59, 45%) whereas community professionals and first responders reported 'other' relationships (n=20, 42% and n=31, 48% respectively).

Most participants were bereaved in the past 10 years (n=189, 75%) and over a third of the participants were bereaved during the COVID-19 pandemic (n=89, 35%).

Table 2 Information on suicide bereavement(s) experienced by professionals (n=252)

Sample characteristic	Healthcare Professionals (n = 135)	Community Professionals (n = 51)	First Responders (n = 66)	Total (n = 252)	Chi-Square (df)	p-value
Multiple bereavements					0.00 (1)	.992
Yes – affected by >1 suicide	115 (85.2%)	40 (78.4%)	57 (86.4%)	212 (84.1%)		
No	20 (14.8%)	11 (21.6%)	9 (13.6%)	40 (15.9%)		
Number of deaths experienced in a professional capacity¹					22.43 (1)	<.001
1-5	90 (68.2%)	35 (70.0%)	20 (30.3%)	145 (58.5%)		
6 or more	42 (31.8%)	15 (30.0%)	46 (69.7%)	103 (41.5%)		
Professionals with personal suicide bereavements					0.78	.376
Yes	84 (62.2%)	34 (66.7%)	36 (54.5%)	154 (61.1%)		
No	51 (37.8%)	17 (33.3%)	30 (45.5%)	98 (38.9%)		
Relationship to the deceased²					13.08 (1)	<.001
Professional	59 (45.0%)	15 (31.3%)	15 (23.4%)	89 (36.6%)		
Family	39 (29.8%)	13 (27.1%)	18 (28.1%)	70 (28.8%)		
Other	33 (25.2%)	20 (41.7%)	31 (48.4%)	84 (34.6%)		

¹Known for n=248 participants (98.4%). ²Known for n=243 participants (96.4%).

Wellbeing of professionals bereaved by suicide

Wellbeing was measured using the scales indicated in Table 3. The distribution of all the wellbeing measures were similar across the three occupational groups (n=252). More than one-third of these professionals reported poor wellbeing (n=88, 35%) as indicated by a score of ≤ 50 on the WHO-5 scale. Less than a quarter of the participants expressed moderate to severe depression (n=40, 16%) and anxiety (n=40, 16%) as informed by a PHQ score of ≥ 10 and a GAD score of ≥ 10 respectively. Participants were asked if they experienced thoughts of self-harm or suicide in the previous two weeks (suicidal ideation) and this was reported by 9% of the sample.

Table 3 Measures of wellbeing of professionals bereaved by suicide (n=252)

Sample characteristic	Healthcare Professionals (n = 135)	Community Professionals (n = 51)	First Responders (n = 66)	Total (n = 252)	Chi-Square (df)	p-value
Measures of wellbeing						
WHO-5 clinical cut-off $\leq 50$¹					3.40 (1)	.066
Yes	39 (29.1%)	22 (43.1%)	27 (40.9%)	88 (35.1%)		
No	95 (70.9%)	29 (56.9%)	39 (59.1%)	163 (64.9%)		
PHQ clinical cut-off $\geq 10$²					2.11 (1)	.146
Yes	17 (12.6%)	10 (19.6%)	13 (20.0%)	40 (15.9%)		
No	118 (87.4%)	41 (80.4%)	52 (80.0%)	211 (84.1%)		
GAD clinical cut-off $\geq 10$³					2.60 (1)	.108
Yes	16 (12.2%)	11 (21.6%)	13 (20.3%)	40 (16.3%)		
No	115 (87.8%)	40 (78.4%)	51 (79.7%)	206 (83.7%)		
Suicidal ideation⁴						
Yes	12 (8.9%)	4 (7.8%)	7 (10.8%)	23 (9.2%)		
No	123 (91.1%)	47 (92.2%)	58 (89.2%)	228 (90.8%)		

^{1,2,3}Known for 251 participants (99.6%).⁴Known for 246 participants (97.6%).

Adverse impacts as a result of bereavement(s)

Around half of the professionals (48%) reported adverse impacts of bereavement within a professional capacity (n=122). The most common impacts were mental health challenges (n=81, 66%), use of alcohol for more than three months (n=43, 35%) and relationship problems, including avoidance of relationships for more than three months (n=42, 34%). Similar impacts were reported for all professional groups.

Supports accessed as a result of suicide bereavement

Overall, informal supports were more commonly accessed compared to formal supports (Figure 1). The most common supports accessed were informal supports from family, friends and neighbours (n=178, 80%) followed by work environment (supports from colleagues and/or employers) (n=129, 62%) and support from information resources (n=90, 43%). Supports from mental health professionals and specialised supports including charities/platforms providing varying forms of interactive support (n=78, 37%) and professionals within the immediate community (n=62, 30%) were less commonly accessed. However, a large proportion of professionals received formal support (n=122, 48%). There was a significant difference between the occupational groups and access of formal supports. Formal support access was more common among healthcare professionals (n=78, 58%) compared to community professionals (n=23, 45%) and first responders (n=21, 32%).

There was a significant difference between the three occupational groups and support received from mental health professionals and specialised supports. These supports were more commonly reported by healthcare professionals (n=47, 41%) than community professionals (n=12, 30%) and first responders (n=10, 19%). The utilisation of information and resources was lowest among first responders, with only a quarter accessing these supports (n=13, 25%), compared with almost half of other professionals.

Professionals who had experienced a suicide in a personal capacity (n=154, 61%) were more likely to access both formal and informal supports. More than half of these professionals (56%, n=86) accessed formal support compared to 37% (n=36%) of professionals bereaved solely in a professional capacity.

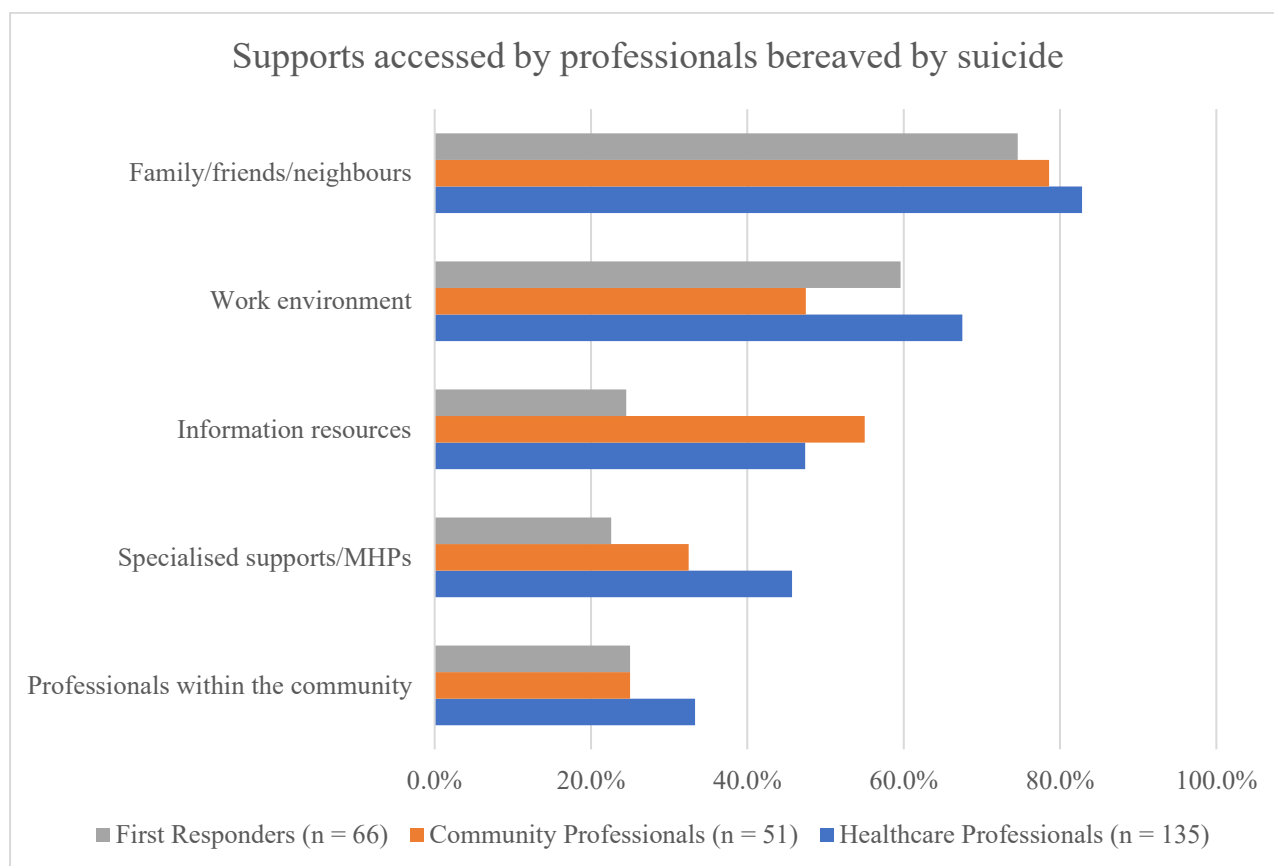


Figure 1 Supports accessed by professionals bereaved by suicide (n=252)

Barriers to accessing support

The most commonly reported reason for not accessing support was 'felt I could cope myself' and this was reported by over a half of the professionals (n=108, 57%) who reported having experienced barriers to accessing support (n=188, 75%). Other common barriers related to individual perceptions were 'reluctance to ask for help' (n=39, 21%) and 'didn't feel grief was important enough/deserved help' (n=35, 19%) whereas barriers that were service related included nothing being offered (22%, n=42) and lack of time (n=29, 15%). The number of barriers reported by the professional groups were similar across the three groups but overall, 40% (n=75) reported three or more barriers.

Discussion

Overall, just under half of those bereaved in a professional capacity reported negative impacts on their wellbeing (48%), and around half of the professionals reported accessing some form of formal support (48%). These professionals may have experienced both personal and professional bereavement(s). Of all occupations, first responders experienced a greater number of deaths by suicide but were less likely to access formal supports.

A scoping review of prevention or early intervention for mental ill health among first responders found that most programs had little impact on mental health with no validated prevention programs available¹⁵. The scoping review noted that these professionals seem to be trying to cope themselves. This was also the most common barrier reported by our sample of professionals (n=108, 57%). The review noted a lack of prevalence data and a lack of focus on validated programs, supports from families and organisational barriers.

Healthcare professionals and community professionals were more likely to access formal supports than first responders. A study examining the impact of patient suicide on general practitioners in the UK recommended the need for training to raise awareness of impacts and supports available in an adverse event²³. Although postvention supports are widely available, a clear set of postvention guidelines targeted to occupational groups are needed. The National Health Service (NHS) launched its first postvention guidance in 2023 which includes a checklist for responding to a colleague's suicide²⁴; such a template may be expanded to other professional groups. The Health Service Executive (HSE) report on 'Improving suicide bereavement supports in Ireland'²⁵, mapped the inconsistencies within the currently available bereavement supports and proposed a future model. The authors noted that although many suicide bereavement supports exist, they are not coordinated or consistent.

Data used in this study was from the first ever suicide bereavement survey in Ireland, thereby providing insight into bereaved healthcare and community professionals. Nevertheless, the cross-sectional design makes it difficult to draw significant conclusions on the impacts of suicide bereavement on professionals as we were not able to compare to those who had not experienced such bereavements(s). Furthermore, there may be several factors which were related to the wellbeing of participants in our sample, which could be explored in future research. Future research could examine the impacts of personal and professional bereavements as well as multiple bereavements over time.

This study included less-studied professionals such as first responders and education providers. As sample sizes are small for each of these professional groups, a larger, more focused study may be needed. Qualitative research may help inform the full range of biopsychosocial impacts experienced by professionals bereaved by suicide.

These results signify the need for better access to postvention supports among professionals, particularly first responders who experienced a greater number of professional bereavements

but accessed fewer formal supports. Well-resourced and easily accessible support networks for postvention must be in place at every workplace to help reduce the emotional burden on professionals.

Declarations of Conflicts of Interest:

This research was funded by HRB Summer Student Scholarship 2023, Grant Number: SS-2023-123.

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References:

1. Spillane A, Matvienko-Sikar K, Larkin C, Corcoran P, Arensman E. What are the physical and psychological health effects of suicide bereavement on family members? An observational and interview mixed-methods study in Ireland. *BMJ Open*. 2018 Jan 13;8(1):e019472.
2. Suicide Statistics 2020 - Central Statistics Office [Internet]. CSO; 2023 [cited 2024 Feb 17]. Available from: <https://www.cso.ie/en/releasesandpublications/ep/p-ss/suicidestatistics2020/>
3. O'Connell S, Tuomey F, O'Brien C, Daly C, Ruane-McAteer E, Khan A, et al. AfterWords: A survey of people bereaved by suicide in Ireland. Cork and Dublin: National Suicide Research Foundation and HUGG; 2022.
4. Cerel J, Brown MM, Maple M, Singleton M, van de Venne J, Moore M, et al. How Many People Are Exposed to Suicide? Not Six. *Suicide and Life-Threatening Behavior*. 2019;49(2):529–34.
5. Pitman AL, Rantell K, Moran P, Sireling L, Marston L, King M, et al. Support received after bereavement by suicide and other sudden deaths: a cross-sectional UK study of 3432 young bereaved adults. *BMJ Open*. 2017 May 29;7(5):e014487.
6. Landers A, O'Brien S, Phelan D. Impact of patient suicide on consultant psychiatrists in Ireland. *The Psychiatrist*. 2010 Apr;34(4):136–40.

7. de Lyra RL, McKenzie SK, Every-Palmer S, Jenkin G. Occupational exposure to suicide: A review of research on the experiences of mental health professionals and first responders. *PLoS One*. 2021 Apr 30;16(4):e0251038.
8. Dransart DAC, Treven M, Grad OT, Andriessen K. Impact of client suicide on health and mental health professionals. In: *Postvention in action: The international handbook of suicide bereavement support*. Göttingen, Germany: Hogrefe; 2017. p. 245–54.
9. Foley S, Kelly B. When a patient dies by suicide: Incidence, implications and coping strategies. *Advances in Psychiatric Treatment*. 2007 Mar 1;13:134–8.
10. Finlayson M, Graetz simmonds J. Impact of Client Suicide on Psychologists in Australia. *Australian Psychologist*. 2018 Feb 1;53(1):23–32.
11. Shao Q, Wang Y, Hou K, Zhao H, Sun X. The psychological experiences of nurses after inpatient suicide: A meta-synthesis of qualitative research studies. *Journal of Advanced Nursing*. 2021;77(10):4005–16.
12. Causer H, Bradley E, Muse K, Smith J. Bearing witness: A grounded theory of the experiences of staff at two United Kingdom Higher Education Institutions following a student death by suicide. *PLoS One*. 2021;16(5):e0251369.
13. Tiech Fire N, Gvion Y, Alkalay S, Zalsman G. The ‘Forgotten Grievors’: The Impact of Pupil Suicide on Post-Trauma and Grief Symptoms in School Staff. *Int J Environ Res Public Health*. 2022 Sep 26;19(19):12160.
14. Lawn S, Roberts L, Willis E, Couzner L, Mohammadi L, Goble E. The effects of emergency medical service work on the psychological, physical, and social well-being of ambulance personnel: a systematic review of qualitative research. *BMC Psychiatry*. 2020 Jul 3;20:348.
15. CIPSRT | Veteran and First Responder Mental Ill Health and Suicide Prevention (2019) [Internet]. [cited 2024 Sep 8]. Available from: <https://www.cipsrt-icrtsp.ca/en/research-summary/test-research-summary>
16. Jacobsson A, Backteman-Erlanson S, Brulin C, Hörnsten Å. Experiences of critical incidents among female and male firefighters. *International Emergency Nursing*. 2015 Apr 1;23(2):100–4.
17. O’Connell S, Ruane-McAteer E, Daly C, O’Connor C, Tuomey F, McDonnell L, et al. Exploring experiences of supports for suicide bereavement in Ireland: protocol for a national survey. *HRB Open Res*. 2022 Jan 7;4:114.
18. Topp CW, Østergaard SD, Søndergaard S, Bech P. The WHO-5 Well-Being Index: a systematic review of the literature. *Psychother Psychosom*. 2015;84(3):167–76.

19. Kroenke K, Wu J, Yu Z, Bair MJ, Kean J, Stump T, et al. Patient Health Questionnaire Anxiety and Depression Scale: Initial Validation in Three Clinical Trials. *Psychosom Med*. 2016;78(6):716–27.
20. Bailey SE, Dunham K, Kral MJ. Factor structure of the Grief Experience Questionnaire (GEQ). *Death Stud*. 2000 Dec;24(8):721–38.
21. McDonnell S, Flynn S, Shaw J, Smith S, McGale B, Hunt IM. Suicide bereavement in the UK: Descriptive findings from a national survey. *Suicide Life Threat Behav*. 2022 Oct;52(5):887–97.
22. Pitman A, De Souza T, Khrisna Putri A, Stevenson F, King M, Osborn D, et al. Support Needs and Experiences of People Bereaved by Suicide: Qualitative Findings from a Cross-Sectional British Study of Bereaved Young Adults. *Int J Environ Res Public Health*. 2018 Apr;15(4):666.
23. Clark S, Smith N, Griesbach A, Rivers D, Kuliwaba A. Supporting general practitioners and practice staff after a patient suicide: A proposal for the development of a guideline for general practice. *Aust J Gen Pract*. 2020 May;49(5):261–8.
24. Identifying the impact of a colleague's suicide on NHS staff, and their support needs, to inform postvention guidance. - NIHR Funding and Awards [Internet]. [cited 2024 Feb 17]. Available from: <https://fundingawards.nihr.ac.uk/award/NIHR129341>
25. HSE Mental Health Operations and the National Office for Suicide Prevention (NOSP). Improving suicide bereavement supports in Ireland [Internet]. 2020. Available from: www.connectingforlifeireland.ie

Appendices

Appendix 1 - CREC Approval

COISTE EITICE UM THAIGHDE CLINICIÚIL
Clinical Research Ethics Committee of the Cork Teaching Hospitals

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University College Cork
Lancaster Hall
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CREC Review Reference Number: ECM 4 (j) 10/8/2021
& ECM 3 (rr) 07/09/2021

Date: 3rd September 2021

Dr Eve Griffin
Research Fellow
National Suicide Research Foundation
4.28 Western Gateway Building
University College Cork
Western Road
Cork

Study Title: Experiences of supports for suicide bereavement in Ireland: A national survey

Dear Dr Griffin

The following documents have been approved:

- Cover Letter dated 17th August 2021
- Safety Protocol and List of Verified Support Services Version 2.0 dated 17th August 2021
- Clarification Email from Professor Eila Arensman dated 31st August 2021.

Full approval is now granted to carry out the above study. The date of this letter is the date of authorization of the study.

Please keep a copy of this signed approval letter in your study master file for audit purposes. The study must be carried out in accordance with General Data Protection Regulation and Health Research Regulation 2018.

You should note that ethical approval will lapse if you do not adhere to the following conditions:

1. Submission of an Annual Progress Report/Annual Renewal Survey (due annually from the date of this approval letter). **We would encourage you to keep note of this date as the CREC will not issue a reminder.**
2. Report unexpected adverse events, serious adverse events or any event that may affect ethical acceptability of the study
3. Submit any change to study documentation (minor or major) to CREC for review and approval. Amendments must be submitted on an amendment application form and revised study documents must clearly highlight the changes and contain a new version number and date. Amendments cannot be implemented without written approval from CREC.
4. Notify CREC of discontinuation of the study
5. Submit an End of Trial Declaration Form and Final Study Report/Study Synopsis when the study has been completed.

Yours sincerely



Professor David Kerins
Chairman
Clinical Research Ethics Committee
of the Cork Teaching Hospitals

Appendix 2 - Data Agreement



National Suicide Research Foundation

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AGREEMENT BETWEEN THE NATIONAL SUICIDE RESEARCH FOUNDATION IRELAND AND MS HANIYA ROSHAN CONCERNING THE SUPPLY AND USE OF DATA FROM THE NATIONAL SUICIDE BEREAVEMENT SURVEY

The National Suicide Research Foundation Ireland (NSRF) to supply National Suicide Bereavement Survey microdata to Ms Haniya Roshan.

Ms Roshan agrees to work with the supplied data in line with the following conditions:

- No attempt will be made to identify the individual participants.
- The data will not be supplied to or accessed by anyone other than the following named persons: Ms Haniya Roshan. The datafile will be password protected and securely stored on a University College Cork server with access restricted to the named researchers.
- The data will be used to examine the impact of suicide bereavement on healthcare and community professionals. This work is being undertaken as part of Final Year Project for a degree in Medicine and a HRB Summer Student Scholarship. The research will be conducted under the supervision of Dr Eve Griffin and Dr Selena O'Connell. The work is due for completion in January 2025.
- The data may only be presented or published in aggregated form so that it is impossible for an individual to be identified.
- The data will continue to be the property of the NSRF.
- There must be consultation with the NSRF (Dr Griffin) before findings arising from the data are presented or published.
- The data will be deleted after this project has been completed. The NSRF will be notified once the data have been deleted.
- Suitable acknowledgement as to the source of the data must be given in publications.
- Authorship rights to any publications arising from analysis of the data will be decided in accordance with internationally-recognised guidelines.

Signed: <u>Eve Griffin</u>	Signed: <u>Haniya Roshan</u>	
Dr Eve Griffin, Principal Investigator, National Suicide Research Foundation, Cork, Ireland	Haniya Roshan, Medical Student, College of Medicine and Health, University College Cork, Cork, Ireland	
Date: 8 th June 2023	Date: 08/06/2023	